Quality Review and Infection Control

How to Get and Keep Your Unit Compliant

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ASC Quality Reporting Program

- Program for ASCs finalized by CMS in Calendar Year (CY) 2012
- Five claim-based measures adopted for CY 2014 payment determination
- CY 2015 added 2 more measures for total of 7 quality measures
- CY 2016 added 1 more measure for total of 8 quality measures

ASC Quality Measures

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>ASC-1: Patient Burn</th>
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<tbody>
<tr>
<td>Outcome Measure</td>
<td>ASC-2: Patient Fall</td>
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<tr>
<td>Outcome Measure</td>
<td>ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant</td>
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<tr>
<td>Outcome Measure</td>
<td>ASC-4: Hospital Transfer/Admission</td>
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<tr>
<td>Process of Care Measure</td>
<td>ASC-5: Prophylactic IV Antibiotic Timing</td>
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<tr>
<td>Structural Measure</td>
<td>ASC-6: Safe Surgery Checklist</td>
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<tr>
<td>Structural Measure</td>
<td>ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures</td>
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<tr>
<td>Process of Care Measure</td>
<td>ASC-8: Influenza Vaccination Coverage Among Healthcare Personnel</td>
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2% Reduction in ASC Annual Payment Update for ASCs Not Meeting Program Requirements

- Definition of ASC: "...a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients." The ASC
  - Must have in effect agreement with CMS obtained in accordance conditions and requirements
  - Is either independent (i.e., not part of a provider of services or any other facility), or operated by a hospital (i.e., under common ownership, licensure, or control of a hospital)
Collecting & Reporting Data
- Reporting claims-based measures started October 1, 2012 for Medicare Primary Patients
- Reporting claims-based measures for Medicare Primary or Secondary started January 1, 2013
- Data for structural measures relates to all ASC patients (Medicare and non-Medicare)

ASC-5: Prophylactic IV Antibiotic Timing
- For all ASC admissions with preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection.
- Preoperative antibiotic infusion initiated within 1 hour prior to time of initial surgical incision or beginning of the procedure (i.e. introduction of endoscope, needle puncture, inflation of tourniquet), or 2 hours prior if Vancomycin or fluoroquinolones are administered.

How to Get & Keep Compliance…
- Quality Study
  - Retrospective data collection from medical records of patients that had preop antibiotic order for purpose of SSI prevention
  - Preoperative antibiotic infusion time
  - Procedure start time (incision, needle puncture, etc.)
  - Analyze results
  - Establish Goal: National average for antibiotics within 1 hour was 87.6% in 2007 using benchmark of 98.6% per the Surgical Care Improvement Project (SCIP)

Renal Intervention Center, LLC Study 2011

<table>
<thead>
<tr>
<th>Dose Timing: administration to incision (Min)</th>
<th>Cefazolin</th>
<th>Clindamycin</th>
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</thead>
<tbody>
<tr>
<td>60 or less</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>Greater than 60</td>
<td>49%</td>
<td>28%</td>
</tr>
<tr>
<td>Unable to Calculate</td>
<td>9%</td>
<td>12%</td>
</tr>
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Problems Identified
- No policy defining process for administration of preoperative antibiotic for SSI prevention.
- Deficiency in knowledge and training of nursing staff with regard to antibiotic timing.
- Routine administration of preop antibiotic within 30 minutes of admission. With patients arrive 1 hour to 1.5 hours prior to procedure start time, excess of 60 minutes noted from infusion time to procedure start time.

Corrective Actions Implemented
- Policy created using CDC Guidelines for Surgical Site Infection Prevention and ASC Quality Initiatives
- Specified infusion for 1st patient to begin 15 minutes prior to scheduled procedure start time. Subsequent patients to begin infusion when previous patient enters Recovery Room. Report to physician if antibiotic infusion greater than 60 minutes from procedure start time.
- Staff Education
  - SSI Prevention/Prophylactic IV Antibiotic Timing
  - New Policy
  - Safe Surgery Checklist/Time Out
Re-Measurement

- 100% compliance with Clindamycin
- 95% compliance with Cefazolin (would have been 100%, however, unable to calculate 5% due to missing pre-op antibiotic administration documentation)

Infection Surveillance

- Have a system in place to track/identify infections that may have been related to procedures performed at your facility
- Keep records of surveillance that confirm you are doing this tracking activity
- Include in your Infection Control Program document your surveillance program. Examples:
  - Follow-up with patient’s primary care providers after discharge
  - Obtain information from physician performing procedure at follow-up appointment
  - Include questions related to infection in post-procedure call to patient.

CMS Requirements for Infection Control

- Infection Control Plan
  - Must follow nationally recognized infection control guidelines (AORN, CDC, HICPAC, APIC, AAMI, etc.)
  - Review/update current policy according to recognized guidelines
  - Reference these guidelines in policies
  - Educate staff on policies and monitor to ensure these guidelines are being followed

Staff Education

- Have a staff education plan and include
  - Which staff members receive training
  - Is the training the same for everyone or are there any differences
  - How often are staff trained
  - How do they receive training
  - Keep documentation of training provided

Infection Control Officer

- Designate qualified professional with training (certification not required) in IC to direct IC program
- Keep documentation of IC officer’s continuing education/training in infection control
**Hand Hygiene**
- Have a hand hygiene policy citing references used, i.e., CDC, *Guidelines for Hand Hygiene in Health-Care Settings*.
- Have soap and water and alcohol-based hand rubs in proper dispensers, installed correctly, and accessible in appropriate areas.
- Train employees on proper technique and occasions requiring hand hygiene and glove use. Document training.
- Conduct hand hygiene analysis as part of quality study. Identify any areas of deficiency and focus on them.

**Injection Practices: Have Policy In Place with References & Documentation of Staff Training**
- Needles used for only 1 patient.
- Syringes used for only 1 patient.
- Medication vials always entered with new needle.
- Medication vials always entered with new syringe.
- Meds that are pre-drawn labeled correctly (time of draw, initials of person drawing, medication name, strength, & expiration date/time).
- SDV used for only 1 patient.
- Manufactured pre-filled syringes used for only 1 patient.
- Bags of IV solution are used for only 1 patient.
- Medication administration tubing & connectors used for only 1 patient.

**Use of Multi-Dose Vials**
- Rubber septum on MDV used for more than 1 patient is disinfected with alcohol.
- MDV used for more than 1 patient are dated when first opened & discarded 28 days of opening or according to manufacturer’s recommendations, whichever is first.
- Do not store or access MDV for more than 1 patient in the immediate area where direct patient contact occurs.

**Single Use Device, Sterilization, & High Level Disinfection**
- Have sterilization policies in place that are based on nationally recognized standards that are referenced (i.e. AORN, CDC, AAMI, etc.).
- Ensure staff involved with sterile processing are trained and keep documentation of that training.
- Keep reference binders from manufacturers of equipment and supplies.
- Know your sterilizer and keep thorough records of routine maintenance i.e. cleaning, PM and CM services, biological testing, and log cycles to include chemical and physical indicator inspection.
- Ensure proper storage of sterile processed items.
- Have policy for high level disinfection processes and keep record of manufactures instructions for equipment/supplies that require high level disinfection.

**Environmental Infection Control**
- Relates to staff who clean your facility.
- Have policies in place for cleaning and disinfecting OR after each case and for terminal cleaning each day.
- Ensure your disinfectant is EPA-registered.
- Have process for staff cleaning high touch surfaces in areas of patient care.
- Have procedure in place for decontaminating gross spills of blood.

**Devices (i.e., blood glucose monitor)**
- Make sure you have single-use, auto disabling lancing devices for use for each patient.
- Train staff on:
  - Use of meter (not used on more than one person unless manufactures instructions for disinfecting followed between each patient).
  - How to clean/disinfect the meter.
Centers for Disease Control

- Click on link for more information
- Hand Hygiene/Hand Washing
- Bloodborne Pathogens
- PPE (Personal Protective Equipment)
- Surgical Site Infection Prevention
- HAI prevention
- Needle sticks
- Fact Sheets examples:
  - Lab resources
  - Hepatitis, TB, HIV
- Guidelines examples:
  - For isolation precautions
  - For disinfection & sterilization in healthcare facilities

Must have written program that includes...

- Bloodborne pathogens
- General safety
- Emergency action plan
- Hazard Communications
- Ergonomics
- Workplace violence
- Tuberculosis
- Training
- Record keeping
- Additional resources

Exposure Control: OSHA

- Click on link for more information
- Inspection usually unannounced
- Inspection based on priorities:
  - Imminent danger to employees
  - Fatality/catastrophe
  - Employee complaint
  - Referral from other government agency
  - Follow-up
  - Program inspection

Must have an OSHA Manual in the Facility

- Manual must be customized to the facility
- Manual is separate from facility policies and procedure manuals
- All employees must know where the OSHA manual is kept

Penalties

- Can be per incident not per standard
- Max $7,000 for serious violation; $1,000 for non-serious
- Up to $7,000 per day for failure to abate
- Example of penalty: staff not using safety devices for safer sharps...employer will be fined

Bloodborne Pathogen Standard

- All employees whose job responsibilities put them at risk for exposure to bloodborne pathogens
- Employees must have access to a copy of the standard and to the employers written exposure control plan
- Hepatitis B, C, HIV
- Employee must complete yearly exposure determinations
- Universal precautions are used
- Hand washing/Hand hygiene
**Engineering Controls**

- Safe sharps
- Disposable phlebotomy hubs
- Sharps containers
- Safety hoods

**Safe Needle Regulations**

- Employer using sharps must
  - Evaluate and use safer sharps
  - Document the evaluation and selections
  - Provide training for selected devices
  - Repeat this evaluation every year
  - Keep record of all injuries involving contaminated sharps

**Hepatitis Vaccine**

- Provide free to all employees at risk for exposure
- Employee may decline but must sign declination
- 3 shots over 6 months
- Titer-1 to 2 months after 3rd shot
- Titer low-repeat series and titer
- Titer still low-non responder
- Keep documentation for 30 years

**Personal Protective Equipment**

- Appropriate PPE (gloves, masks, face shields, goggles, gowns, etc.) provided by employer with training on what to use/how to apply and remove provided by employee
- Maintained, replaced by employer
- Must fit properly
- Must accommodate latex allergy

**Laundry**

- Employees cannot take contaminated items or PPE home
- Provide on-site or linen service
- OSHA does not provide laundry instructions. CDC recommends 160 degrees F or 125 degrees F plus 1 cup bleach

**Biohazard Waste**

- Include in policy and training what items to discard into biohazard waste containers and how to dispose of biohazard waste
  - Gloves-if visibly contaminated
  - Saturated or caked absorbent material (gauze, bandages, etc)
  - Liquid or semi-liquid blood or other potentially infectious material
**Housekeeping**

- Follow proper procedures for cleaning and disinfecting
- Use EPA registered disinfectant
- Have a written schedule for general cleaning
- Do periodic inspections to evaluate the cleaning service provided

**Labeling**

- Ensure you are labeling with the biohazard symbol where required
  - Sharps containers
  - All biohazard waste containers
  - Where biohazard waste materials are stored
  - On contaminated equipment that must leave the facility for servicing unless decontaminated

**Post Exposure Evaluation and Follow-Up**

- Must be offered immediately
- Free of charge to employee
- Confidential
- Under supervision of licensed healthcare provider
- According to current CDC guidelines
- Informed consent required for HIV testing
- Exposed employee may decline testing or have blood drawn and preserved for 90 days while waiting to
  - make a decision
  - Treatment & follow-up

Recommend: exposure “kit” or “file” containing all instructions to follow, blood tubes to use to draw, consents for HIV testing, etc.

**Support**

- Of management

**Resources Available**

- ASDIN Associate Member Web site, www.asdin.org
- www.cdc.gov provides A-Z index to look up an specific area you need information about
  - www.cdc.gov/HAS/settings/outpatient/infection-control.html, information, guides and checklists you can use along with list of resources, i.e., minimum expectations guide, infection prevention checklist;
  - www.cdc.gov/healthcare-infection-control-guidelines for the Healthcare Infection Control Practices Advisory Committee (HICPAC), i.e., hand hygiene, sterile processing, isolation, reporting HAIs, etc.
- Beckers ASC Review-Operating Room Clinical Quality and Infection Control (Champions Kit) www.BechersASC.com
- International Sharps Injury Prevention Society www.ispis.org (monthly newsletter)
- Safe Care Campaign www.safecarecampaign.org, free on-line reference guide to preventing infections

**Support continued…**

- ASC Collaboration www.ascquality.org, hand hygiene toolkit and policy template, safe injection toolkit referenced to CDC and WHO, quality report of ASC data;
- 3M Solutions www.solutions.3m.com, access to Sterile U on-line for free CME for sterile processing program and staff education resourced to CMS, AAMI, AORN, etc.
- Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) www.apic.org/patient-safety, includes free, ready to print infection control material (posters, flipcharts) to display/share with patients, list of resources, reports, and research on infection control
- Database of Downloadable Safety and Quality Tools and Resources, www.beckersasc.com/downloadable-patient-safety-tools-and-resources.html, information, guides and checklists you can use along with list of resources, i.e., minimum expectations guide, infection prevention checklist;
- www.cdc.gov/hipac/pubs.html, guidelines from the Healthcare Infection Control Practices Advisory Council (HICPAC), i.e., hand hygiene, sterile processing, isolation, reporting HAIs, etc.
- Beckers ASC Review-Operating Room Clinical Quality and Infection Control (Champions Kit) www.BechersASC.com
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- Safe Care Campaign www.safecarecampaign.org, free on-line reference guide to preventing infections

**Staff Education Ideas**

- Self-guided power point in-service
- Poster project
- Bulletin Boards
- Game, i.e. jeopardy
- Guest speakers
- Videos Glowing germ hand hygiene demonstration
- Hand Hygiene certification
Staff Education Ideas continued…

- Demonstrations to observe and pick out IC violations, deficiencies, improper PPE use, etc.
- Use of posters, buttons, signs
- Facility walk-through
- Scavenger hunt
- Hand hygiene surveillance
- E-mail

References

- ASC Quality Collaboration, www.ascquality.com
- American Society of Diagnostic & Interventional Nephrology, www.asdin.org
- Centers for Disease Control, www.cdc.gov
- Occupational Safety and Health Administration, www.osha.gov

Self Evaluation

- Quality Studies
- Medical Record Audit
- Observe
- CMS Infection Control Surveyor Worksheet
- Accreditation Handbooks/Self-Assessment Books
- Variance Reports

It was on a short-cut through the hospital kitchen that Albert was first approached by a member of the Antibiotic Resistance.